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SOCIAL SECURITY AND HOSPITAL INSURANCE FOR THE AGED

by

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Secretary of Health, Education, and Welfare

Good health is man's most treasured gift. It represents, at its peak, his harmony with the physical, psychological, and social environment he lives in. Good health, then, is the result of a multitude of factors carefully balanced and blended.

The Department of Health, Education, and Welfare is deeply involved in helping to maintain this delicate balance, in helping to guard and improve the health of all Americans. The Department's work ranges from the development of new vaccines against disease to the prevention of accidents, to the guarding of the environment against manmade pollutants, to assuring the purity of food and drugs—to charting ways to make medical care more readily available to those who need it.

Considerable progress has been made in the general improvement of our health—as attested by an increase of over 20 years in the average lifespan since the beginning of this century. The promise of the future in the conquest of disease and disability is virtually unlimited.

To realize the promise of the future, however, we must continue our dynamic and aggressive pursuit of better health. Our Nation must continue to invest large sums in medical research. We must accelerate our development of the manpower and facilities needed to more fully apply the medical knowledge we have. As our technology continues to advance, we must pay more attention to what we are doing to our environment. If we are not careful, the benefits of industrial progress could, in time, be outweighed by damages to our air, our water, our food, and, ultimately to ourselves.

There is no doubt that we will meet these challenges. We must, because health is basic to our progress as a nation. The decision

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was made long ago that the combined forces of Federal, State, and local government should be used to assist private individuals and organizations toward the mutual goal of good health. History has amply justified the wisdom of this decision. It has also indicated the path for the future.

We have also come to appreciate that health is not just a matter of having an adequate number of professional people; of developing the knowledge needed to treat, heal, and prevent; or of building and equipping diagnostic and treatment centers. The distribution of medical care in our country is carried out—as it should be—within the context of our free-enterprise economy. This means there is a bill to be paid when medical services are provided—usually a large bill when severe illness occurs. On top of this, medical expenses are unpredictable. This presents a problem to all people—how to purchase the medical care they need.

For most people, the answer is private health insurance. This way, most of us can make regular monthly payments and, in return, be insured against medical expenses that otherwise would be difficult or impossible to meet. This system works—for those who can afford to purchase health insurance. But for one segment of our population—our older people—private health insurance can never be a fully satisfactory solution. Because of their high risk and generally low incomes, the cost of adequate health insurance is prohibitive for most older people. Aged people need about 2½ times as much medical care as younger people—but they have only half as much income. This presents a so-far insoluble problem for private insurance. It is because adequate private health insurance is beyond the means of most older people that social insurance is needed. An aged person may be financially independent to the extent that he can purchase the necessities of life and even some of the luxuries. He probably has social security and may also have private life insurance, investments, savings. If so, he can make his own way—until he faces the almost inevitable, budget-shattering consequences of severe illness—the costs of which he knows he cannot pay.

When serious illness comes to the aged person, life ceases to be a joy and becomes a burden. Income is inadequate to buy the needed health services. Savings go. Debts are incurred. Lastly, there is the appeal to charity. The loss of economic security—economic security built up over a lifetime—is all too often the price the aged must pay to get the medical care they need. As a result, sickness and poverty too frequently visit the aged together, with poverty remaining as a permanent guest. While this problem has always faced older people to a certain degree,

only in recent years has it attained its present proportions. There are several reasons for this. For one thing, medical care is much more expensive now than it used to be, and much more and better medical care is available and helpful to older people than was the case a few years ago. Daily hospital charges are now four times as much as they were in 1946. Then too, not so many years ago, when an older person got sick, medical science could not work the wonders it does today. He either spent the remainder of his life suffering from a chronic condition, perhaps bedfast, or else met an untimely death. But now, thanks to the knowledge and techniques available to the medical profession, this consequence is not as likely as it used to be.

Many an older person receives treatment which was not possible before and is returned to his home. He lives, much as he did before, and, in doing so, he is again faced with the probability that, sooner or later, he will once more return to the hospital. Thus, effective medical care and the fruits of medical research are themselves creating a demand for a greater degree of medical care.

This is what medical care is for—to make life longer, more healthful, and as free as possible from the pain and inability caused by disease and injury. That we have progressed so far is a magnificent achievement. As always, we must now take account of the problems that accompany progress. This greater need for medical care by older people, and its increased cost, is only one reason behind the present problem of how to meet the health needs of older people and at the same time maintain their economic security, self-respect, and independence.

Adding to the demand for medical care for older people is the increasing number of citizens who are aged. In 1900, only 4 percent of our total population was 65 and over. Even as late as 1930, people over 65 amounted to only 5 percent of the population. But today, there are close to 18 million people over 65 in the United States, representing about 10 percent of our total population. In addition, more of the aged are fully retired than used to be the case. And so we have a combination of a greater proportion of older people in our community; a greater need for medical care by this segment of our community; and, for the great majority, reduced income.

The emergence of these separate, but related, developments makes it necessary that we provide a way aged people can get the medical care they need, in spite of the heavy expense, and yet retain the economic security and independence they have slowly and painfully built up over the years.

Hospital insurance for the aged through social security would contribute toward both of these goals. It would provide a way that much of the high costs associated with serious illness in old age could be met. It would do this by permitting workers to provide and pay toward this protection for themselves through payroll contributions during their working years. The two most important values of the proposal are that hospital insurance for the aged through social security would provide additional *protection* against poverty and that this protection would be financed by *contributions* from the very people it will protect. In short, hospital insurance through social security is simply a program to help people help themselves.

This specific value is not to be found in the public assistance approach to health care costs. It is because of this basic difference that both social security hospital insurance and Kerr-Mills medical assistance for the aged are needed. These programs are not alternative solutions to the same problem, as many seem to believe they are. Each approach is needed—each to do the job it is most fitted for.

Social security hospital insurance is designed to pay for expensive and unpredictable health care costs of old age and to provide this payment as an earned right, available when it is needed, rather than only when all other sources have been exhausted. Medical assistance for the aged under Kerr-Mills would still have an important role to play for those with special needs or special problems. With the basic protection provided under the hospital insurance program for the aged, the program of medical assistance for the aged would be better able to do a meaningful job with the funds available. Thus, all States should take advantage of the opportunity to provide medical care to their indigent and medically indigent residents.

The present administration believes that the addition of hospital insurance to our present social security system is the most practical, conservative, and economical way to help older Americans meet the cost of the health services they need without forfeiting their economic independence, without draining their children's resources, without applying for public charity.

ECONOMIC PROBLEMS IN THE DISTRIBUTION OF MEDICAL CARE

by

Wilbur J. Cohen*
Assistant Secretary of Health, Education, and Welfare

We are the richest Nation in the world today with the highest standard of living. The advances we have made in the prevention and treatment of illness would be as astounding to our great-grandfathers as the rockets we are aiming at the moon, the missiles we are sending into space. Over the past 30 years alone, the proportion of our gross national product spent on health and medical care has risen from 3.6 percent in 1928-29 to 5.7 percent in 1960-61—in dollars from $3.6 billion to $29.0 billion. The rate of increase in expenditures has been greater than the rate of population growth—an indication that increased and improved medical services are reaching more people each year. But, modern medicine costs money, and, although more people today are receiving medical care than ever in our history, adequate medical care is still not available to millions of our citizens—mainly because they cannot afford it.

We have a population of almost 190 million men, women, and children living in some 56 million households. More than one-sixth of them are in families with incomes so low that they do not owe any income tax; that is, less than $1,325 for a mother and child; less than $2,675 for a married couple with two children; less than $4,000 for a family of six. Half of our aged couples have an annual income of less than $2,500; half the aged persons living alone have less than $1,000 a year to live on. It will be conceded by almost everyone that these families have incomes that are considerably less than adequate. An estimated 17 million children—one out of every four children in our population—live in families with inadequate incomes. Among the other several million poor persons are people who never recovered from the

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Great Depression of the thirties and those affected by automation and other shifts in the pattern of our industrialization.

The Poor Are Ill More Often

Illness is not predictable. Nor can the poor choose inexpensive illnesses. The very fact that they are poor—have inadequate diets, substandard housing, unhygienic living conditions—may make them get sick more often than people with higher incomes. And, they stay sick longer. During the year a person living in a family with an income under $2,000 a year (about one in seven of our total population) will be sick enough to restrict his usual activities for the whole day an average of 28 days a year. A member of a household with an income of $7,000 or over will have his activities so restricted an average of only 13 days a year. But those with family incomes of less than $2,000—with more than twice the illness—will consult a physician only five times per year, while persons in families with incomes of more than $7,000 will consult a doctor six times a year.

An aged person in a family with less than $2,000 income experiences nearly 3 days restriction of his activities for every 2 by a person of the same age with an income of more than $7,000, but he will consult the doctor an average of seven times a year, while his contemporary with an income of more than $7,000 will consult the doctor an average of nine times a year. Sickness makes it difficult for a poor person to work steadily and hold a job, and so income goes down. Then, there is less money than ever to spare for medical care. And, the spiral takes the victim down deeper and deeper into poverty.

A poor person may be able to get along for a time without consulting a doctor—until his illness reaches an acute stage—but, when it does, if he does not die first, he may have to go to the hospital. In fact, according to figures gathered in the National Health Survey, people with low incomes are more likely to enter a hospital than people with high incomes, and, when they do go in, the low income patients stay in the hospital longer. These poor people who get sick and who go to the hospital are statistics. But, they live among us; and their misery, buried in the statistics, is very real.

> Margaret H. was widowed 63 years ago after only 2 years of marriage. She went to work for a milliner and after 5 years of working 12 hours a day, 6 days a week under the sweatshop conditions of the period, had saved enough to buy an old house in which to operate a boarding house. She was over 80 when she decided to retire. With her social security checks of $80 a month and $2,000 cleared from the sale of her house, she moved into the home of an elderly cousin, confident that she could live out her remaining years in dignity, if not in luxury. Late in 1962, Mrs. H.

fell and broke her hip. After a little more than 6 weeks in the hospital, her carefully cherished $2,000 was exhausted. A few weeks later, she was a "charity" patient. When she died in April, her cousin said, "It was not from a broken hip but from a broken heart."

John W., a successful businessman, retired 8 years ago at the age of 70. He owned a home and had $10,000 in other assets, in addition to social security benefits of $105 a month for himself and $52.50 for his wife. When his wife died of cancer, 3 years ago, Mr. W.'s $10,000 in assets were exhausted. Three operations for his wife and the costs of her terminal illness, plus his own hospitalization for a heart condition on three occasions, had exhausted them. The private health insurance policy he had prudently purchased before he retired was not renewed after the first year and he found it impossible to purchase the protection needed from another company. The required health history statement brought rejection of his application, or else an offer to insure him and his wife only with a waiver of benefit for their existing conditions. A year or so ago he sold his house. He lives in a small apartment in a quiet but shabby neighborhood populated by lonely old men and women. Many of them, he supposes, are living on much less than his $105 social security benefit. He tells of the old gentleman he met shortly after he moved in who offered him a piece of hard candy from a crumpled paper sack with the remark, "Have one, it helps kill the appetite." John W. still has a little money left from the sale of his house, but he fears that his next heart attack will exhaust it.

What Are the Facts About Private Health Insurance?

Private health insurance is available from three principle sources: commercial and nonprofit insurance companies; the nonprofit Blue Cross and Blue Shield plans; and from nonprofit independent plans. Over 800 life and casualty insurance companies write various types of medical care insurance today on a group or individual basis or both. They have sold policies covering hospitalization benefits to some 91 million persons, 57 million under group policies and 34 million under individual policies. A somewhat smaller number of persons is covered for surgical benefits and about half of the total for doctors' calls in the hospital or office and home. A total of 77 Blue Cross and 70 Blue Shield plans together have enrolled about 58 million persons for hospital benefits, 49 million for surgical benefits, 45 million for doctors' visits in the hospital for nonsurgical cases, and perhaps 8 million for doctors' visits in the office and home. There are about 800 independent plans that have enrolled about 7 million persons for hospitalization and about a million more for various types of medical services.

Taking all types of plans together and eliminating duplication due to individuals having multiple policies or coverage through more than one type of carrier, some 74 percent of the civilian population as of the end of 1961 had some form of hospital-ex-

pense insurance, 69 percent had some type of surgical-expense protection, and 51 percent had some coverage against the cost of medical services other than surgery.

These figures on the percentage of the population with one or another type of health insurance coverage must be understood for what they are and what they are not. The figures do not mean that the specified percentage of the population had adequate health insurance coverage. The insurance coverage that people have against the cost of the various services varies from poor to good. The person who has a policy providing $10 a day for 30 days against the cost of room and board and $100 against the cost of the ancillary hospital services figures in these statistics on the same basis as one who has complete coverage of all hospital care in a semiprivate room for up to 365 days in any one illness.

Population Coverage Uneven

The percentage of the population having some type of health insurance coverage varies widely from State to State—from about 92 percent in New York to 47 percent in Mississippi—and by income level. The National Health Survey found that as of July-December 1959, only 33 percent of persons in families with incomes under $2,000 had some type of hospital insurance as against 85 percent of persons in families with incomes of $7,000 or more.

Adequacy of Health Insurance

Too many people are without any insurance, and in general they are people with low incomes who need it most. Many who have some insurance have coverage which is so meager that it leaves them poorly protected in the event of serious illness. Most of existing insurance does little to encourage preventive or even early care. Voluntary health insurance has come a long way in the past 25 years, but it has a long way still to go. And it must be acknowledged that, in the main, it is and will continue to be a mechanism for meeting some of the medical expenses of those who have incomes which leave something to spare after the costs of food, shelter, and clothing are met.

There is no indication that it will ever be able to provide a way for those with inadequate incomes to get the medical care they need. These people, an estimated 33 million of our population today, do not have incomes adequate to meet even the essential needs of today's level of living. They are better off, to be sure, than the peasant of southeastern Asia, living on three bowls of rice a day in a grass shack, but they are not sharing the level of living we hold out to the world as the American standard of living.

Our Economy Must Catch Up With Technological Progress in the 20th Century

This is the heart of the matter. And the problem facing our Nation today is how to organize our economy and our society so that the Nation can make full use of its huge technical capacity and its wealth of potential human resources. Our technology has been progressing at a whirlwind pace, but our economy—our method of distributing our material abundance—is still organized along the same lines as it was a generation ago. Just as the individual, private enterprise, and the Government all play roles in our present pattern of economic security, all will have a part to play in helping to mold the pattern for the future. The task will not be easy, and it will not be accomplished overnight because the causes of poverty and of the dislocations in our economy must be eliminated before poverty itself can be permanently abolished.

Among these causes are technological unemployment—in the city and on the farm—a rapidly increasing population, lack of education, broken families, disability and disease, the slum psychology, and discrimination against minorities. And, among the minorities I list the aged, both white and nonwhite.

There is a long, long road ahead, but "the longest journey begins with but a single step." And, the first steps could begin right now. Some are being taken—the program for aid to depressed areas, manpower retraining, the Community Health Services and Facilities program. The Public Welfare Amendments of 1962 are directed toward finding and treating the causes of dependency. How nearly this goal is realized will depend upon whether full advantage is taken in the States and localities of the legislative changes and the additional Federal funds now available. Other changes are coming. President Kennedy has recommended a tax reduction to get the economy moving upward at a faster rate and also action in expanding opportunities for youth —in employment, training, and education—to help today's youth in low-income families to climb out of the subculture of poverty.

With income levels raised, with more people working and able to obtain and pay for medical protection provided under private group health insurance plans, many of the present inequities in the distribution of adequate medical care would be eliminated.

But, for the aged person with a low income today, there is no prospect of an improved future—only a certain knowledge that failing strength, sickness, and disability will be ever more constant companions during the years or months left to him and a fear that the last thing he may see before he closes his eyes

forever will be the walls of a charity ward. Because of the special problems of the aged, the President has asked Congress to enact now a hospital insurance program for aged persons to be financed through the existing social security program.

Why a Special Program for the Aged?

People over 65 are ill much more often than younger people, and their illnesses last longer. They have medical costs twice as high as younger people, and they must meet these costs out of annual incomes that on the average are only half as much.

Although an aged person may not be poor at the time he first retires, his financial situation deteriorates as time goes on—even without illness. He uses up his assets, and his fixed income feels the effect of inflation. And more and more people today are living on into their 80's and 90's; 10,000 are past the century mark. Most of these people who live to an advanced age outlive their assets.

More People Are Living To Be Old

Paradoxically, this situation is an indication of our ability to provide a better life for our citizens. With the diseases, the malnutrition, the working and living conditions that existed in earlier centuries, many people now grown old would have died in their childhood or youth. According to the 1960 census, we had 16.6 million aged, 1 out of every 11 people in our population. We now have nearly 18 million aged. During the years between 1950 and 1960 alone, the number of people aged 85 or over increased by 60 percent. It is in these oldest age groups that the costs of illness become especially high.

Those Who Most Need Health Insurance Don't Have It

Among the aged, as among the rest of the population, it is those most in need of health insurance who are least likely to have it: The chronically ill, the ones not working, and those with low income. And, these people generally find the costs of insurance beyond their means or are considered too poor a risk for the commercial insurer. Some who have protection find the policy canceled when they most need it—when they develop expensive, long-drawn-out "conditions," or when they reach the older age brackets, although currently more noncancelable policies are being written.

Hospital Stays Can Be Lengthy, Unpredictable, and Costly

Although the average elderly patient leaves the hospital within 2 weeks, nearly 1 in 10 remains a month or longer. The longer

his hospitalization lasts, the more likely is the aged person to need help in paying for his care. The burden of paying for hospital care is even greater when one takes account of those who do not leave the hospital alive. Terminal illnesses often are especially expensive and those at the older ages, who are most likely to die, are least likely to have any insurance. Often they leave a legacy of debt with a heavy burden on widows and children.

No one can foresee just when he will enter the hospital—although 9 out of 10 persons who reach age 65 are sure to go at least once in their remaining lifetime. But, all the evidence indicates that, when one does have to go, he will have unusually high medical bills of all kinds. Aged social security beneficiaries in general hospitals during 1957 had total medical bills for the year five times as high as those with no hospital illness—not counting the costs of persons who did not know what such costs were, often because some care was given without charge or paid for directly by a public or private agency.

At December 1962 prices an elderly couple with one or both members receiving hospital care could expect their combined medical bills for the year to total about $1,200. For the elderly person without a spouse, a hospital stay might mean average medical bills for the year of about $925. With half the aged couples having less than $2,500 income and about half the single aged persons less than $1,000 it is obvious that most of them would be hard put to pay such a bill and still have enough left for groceries and housing—unless they had the benefit of health insurance, could count on getting free care, or received help from relatives. Except for an owned home, few of the aged have assets in substantial amounts. Those who do are more likely to be the relatively small number who already have the advantage of higher income.

How Medical Expenses of the Aged Are Paid

How then do the aged manage when ill? Some seek help from relatives and, failing that, from public assistance. Some borrow money. A small number can manage on their own, especially if they have insurance. Some, as is true of all low income groups, probably never get the care they need. Relatives provided help with medical bills for every seventh social security beneficiary couple and every fourth nonmarried beneficiary who went to a hospital. Many beneficiaries who paid their own bill could do so only because relatives had either taken them into their own home or contributed in cash to their living expenses. Typically, the relatives to whom old people must turn for help already have

families and children to take care of or are themselves old enough to be facing their own problems of retirement.

Some aged persons with medical problems ask for public assistance—either to meet the emergency itself or for regular living needs after using their resources to pay for the medical care. In the first half of 1962, just about every third person approved for old-age assistance needed it directly or indirectly as a result of health difficulties. Among people getting the assistance to supplement social security benefits, the proportion obtaining assistance on account of medical needs was as high as two in five. Currently about half the aged going on the old-age assistance rolls are social security beneficiaries.

The kinds of medical services and the amount of care provided through public assistance vary greatly from State to State. Some State public assistance programs pay for relatively comprehensive services, others meet emergency medical needs only. In December 1962, vendor payments for medical care under the old-age assistance averaged $15 per recipient; the range was from a low of $.41 per recipient per month in one State to a high of $72 in another.

The 1960 amendments to the Social Security Act increased the Federal matching funds for vendor payments under old-age assistance. (Vendor payments are those made directly to hospitals, physicians, and other suppliers of medical services.) Under the Kerr-Mills Act, Federal matching grants were provided for a new program of medical assistance to aged persons not eligible for old-age assistance but whose income and resources are insufficient to meet the cost of needed medical care. As of April 1963, medical assistance for the aged programs were in effect in half the States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. The services provided under these new programs also vary widely. In December 1962, about 53 percent of all expenditures under the Kerr-Mills program were being made in two States—States that transferred to medical assistance for the aged most of the nursing care cases on their old-age assistance rolls. Liberalization of the Federal contribution in the federally aided assistance programs has often meant more improvement in States already doing a better-than-average job than in those where standards and available funds were low.

Aged persons with no health insurance and in need of hospitalization are more likely to go to a public hospital than patients with health insurance. Public hospitals more commonly than private institutions must tailor their charges to ability to pay, including taking as public charges those who cannot pay at all.

Public programs are now responsible for 28 percent of total expenditures for medical care for persons aged 65 and over. This much of the burden of medical care of the aged population already falls on the community at large. One may well question, however, whether the cost of this burden is distributed among all our citizens in the most efficient and equitable fashion.

Trends in Health-Care Costs

Over the past decade, prices of all goods have gone up but not as much as has income of the population. Real income, as measured in purchasing power, has improved for most Americans. On the other hand, medical care prices, and especially the cost of hospital care, have risen more than other prices and by and large have outstripped gains in income. This has been a serious problem for all low income groups and particularly so for persons aged 65 and over.

A part of the increase in the cost of hospital and medical care has resulted from improvements in the earnings and conditions of work of hospital employees who have been among the relatively lowest paid groups and are among the last to move from a 12-hour to an 8-hour working day. Changes in medical technology, such as the increasing use of specialized equipment and expensive drugs and antibiotics, while increasing the power of medicine, have also made it more costly.

The organization of medical services is also in process of change. The hospital is assuming a new importance as the center for medical care in a community, at the same time that more effective use of home health services and skilled nursing home or other services is making it possible to transfer many long-term patients out of the hospital, to their benefit as well as that of the community. The further development of a wide range of community and social services can have a significant effect on medical-care problems.

In planning for the next decade, it seems reasonable to assume that the overall cost of medical care will increase at not less than the rate of increase in our total national output—and probably at a somewhat faster rate. Whatever the future costs may be, the question of how the benefits of modern medicine can best be assured to all who need them will be one of the most important challenges to our ingenuity.

Hospital Insurance for the Aged Under Social Security

The President of the United States said in his message on the elderly citizens of our Nation in February 1963:

Hospital insurance for our older citizens on social security offers a reasonable and practical solution to a critical problem. It is the logical extension of a principle established 28 years ago in the social security system and confirmed many times since by both Congress and the American voters. It is based on the fundamental premise that contributions during the working years, matched by employers' contributions, should enable people to prepay and build earned rights and benefits to safeguard them in their old age.

There has been opposition to this proposal on the part of certain organized groups. No responsible person or responsible organization has said that there is no need—that action is not necessary and necessary now. The difference of opinion is about how the problem shall be met—whether the more expensive costs of illness in old age should be paid through our contributory social security system or whether an ever-growing number of the aged must be taken care of as charity cases, requiring annual appropriations from the general revenues of the State and Federal Governments.

The medical bill will be paid one way or another. If it is not paid through the social security trust funds out of contributions from workers and their employers, it will be paid by every taxpayer in some other way. Briefly, the program proposed by the President would provide payment for basic hospital services, skilled nursing-home care after discharge from the hospital, outpatient hospital diagnostic services, and visiting-nurse and other health-worker services in the old person's home.

In the payment of his hospital bills, the aged person would have a choice of three plans. He could choose:

1. Up to 45 days of hospital care at no cost to him;
2. Up to 90 days of hospital care at a cost to him of $10 a day for the first 9 days, with a minimum payment of $20; or
3. Up to 180 days of hospital care, with him paying either the national average cost for 2½ days or the hospital's customary total charge for the care given—whichever is less—but no more than $92.50 under the rates estimated for the first 2 years of the program.

Benefit payments would cover the cost of all services in semiprivate accommodations, drugs, and supplies customarily furnished for the care of patients in a hospital or skilled nursing facility. No payment would be made for the services of personal physicians and private duty nurses or luxury items furnished at the request of the patient.

Social security hospital insurance would be provided to all people over 65 who are entitled to social security or railroad retirement benefits. In addition, all people now over 65 as well as those becoming 65 in the next few years who do not or will not

qualify for social security benefits would be eligible for the benefits.

Hospital insurance through social security would be financed by an increase of ¼ of 1 percent in social security contributions for both employees and employers (0.4 of 1 percent for self-employed persons) and an increase in the taxable earnings base from $4,800 to $5,200. Part of the income from the increase in the earnings base will go for higher cash benefits for those earnings over $4,800 a year. The cost of the hospital insurance program to the average worker would be about $.25 a week.

If hospital insurance were provided under social security the workers' payments would be spread over their working lifetimes and would be matched by payments by their employers, so that only modest employee payments would be required.

Those already old, it is true, would receive this hospital insurance protection without having contributed to the cost. But this is one of the advantages of a social insurance program. Under social insurance, the benefit of any improvements that are made in the program are made available to those who are already retired as well as those who will retire in the future. This has been the case with all the social security benefit increases enacted since the program started.

The cost of providing hospital insurance protection to the small proportion of the present aged who have not had the opportunity to participate in the social security program would be met from general revenues. Since almost everyone who will reach 65 in future years will be eligible under the social security program, this would be a relatively temporary arrangement.

Because of the practically universal coverage of social security, the problems of adverse selection of high-cost risks that plague private health insurance and that require exclusion of the pre-existing conditions and similar restrictions do not exist for social security; and it can use the advantages of group coverage to keep administrative expenses to a minimum. Collection of contributions and recordkeeping for hospital insurance would add little or no cost to going social security operations. All administrative costs are expected to be about 3 to 4 percent of benefits.

Social security protection has many other advantages over public assistance. Social security avoids the application of a means test, which most people find distasteful and humiliating. It would cover the cost of quality care in every State of the Union. It would cover the cost of care at the time when it was needed without delays for investigation of financial capacity. It would not destroy the incentive to save or for personal and employer arrangements for additional protection, which make the individual

ineligible for aid under a means-test program. It would, most important, prevent dependency among the aged rather than merely offering aid to the poverty stricken.

Finally, hospital insurance for the aged under social security would fit into the existing pattern of our other institutional arrangements. It would work side by side with private insurance, just as retirement benefits and private pension plans have worked together. It would relieve public assistance of a great part of its present burden and permit the States to offer truly meaningful aid to the few in specially disadvantaged circumstances. It would provide a basic benefit that could easily be supplemented on a private basis. It would encourage free choice by removing cost barriers that now stand in the way of free choice.

It is for all these reasons that the President has said of his proposal, "Health insurance for our senior citizens is the most important health proposal pending before the Congress. We urgently need this legislation—and we need it now."

Our social security program has been in operation for over a quarter of a century. When the program was enacted in 1935, there were dire predictions about what it would do to our form of government, to our economy, and to the moral fiber of our citizens. Social security has not led to socialism; it has not destroyed free enterprise; and it has not made our people into "regimented slaves" or "slackers." Today few of the opponents who made these predictions would want to risk the ups and downs of our economy without the cushion of the $1.2 billion paid out each month to 18 million retired and disabled workers and the widows and orphans of workers who have died.

Twenty-six years ago the United States Supreme Court ruled in a 7 to 2 decision that the Social Security Act was constitutional. Justice Cardozo wrote at that time:

> Needs that were narrow or parochial a century ago may be interwoven in our day with the well-being of the Nation. What is critical or urgent changes with the times. . . .

Certainly the soaring health costs of the aged constitute an urgent and critical problem affecting the well-being of the Nation. It is puzzling to find the President's logical, conservative, and fiscally sound proposal called "a step toward socialism." By accepted definition, "socialized medicine" is a system in which the Government owns and controls hospitals, and hires, pays, and controls doctors. The plan the President has proposed would do none of these things. It is simply a means of financing the costs of hospitalization, nursing-home care, and certain home health services for the aged through the social security system. Each

person would have the same freedom of choice of physician and hospital that exists today. Indeed, he would have more. One does not have very much of a choice of services if he does not have the means to pay for them.

Additional Health Care Facilities and Personnel Would Be Needed

The ability to afford adequate health care protection is, of course, meaningless without adequate health care facilities. While the enactment of the proposed Hospital Insurance Act would in itself stimulate the construction of more facilities and the provision of additional services, the communities would need additional help so that these facilities and services would be available where everyone could use them.

A good start was made in the enactment of the Community Health Services and Facilities Act which was mentioned earlier. Under this legislation, additional Federal funds are helping States and communities to develop new and improved community health services, to build more nursing homes, and to provide better care in homes of patients as well as in nursing homes. In addition, the President has recommended legislation to authorize planning grants to public and other nonprofit organizations to assist them in developing comprehensive, areawide plans for the use and construction of all types of health facilities. These studies will enable such organizations to study ways of attaining maximum economical use of existing facilities, how hospital facilities can be built, and how services within hospitals should be organized and administered to provide the best possible care with the personnel available.

The provision of adequate health care to all our citizens requires an adequate supply of well-trained personnel. This means that the number of doctors and dentists must keep pace with our growing population. To achieve this goal, we will need new schools and teaching hospitals to train our future physicians and dentists.

President Kennedy has made four recommendations which, if adopted, will bring the goal closer:

1. Grants to help our academic institutions plan new facilities for medical and dental schools and to explore ways of improving the whole educational process.
2. A 10-year program of matching grants to assist in the construction, expansion, and restoration of medical and dental schools to increase their capacity.

3. A program of student financial assistance for talented but needy medical and dental students.
4. Cost-of-education grants to schools for each Federal scholarship to meet costs not covered by tuition and fees.

Conclusion

The equitable distribution of adequate health care to all our citizens requires a wide range of private and public medical care resources. With private expenditures accounting for about three-fourths of all expenditures for health services, private individuals and nongovernmental groups will continue to bear a major responsibility for promoting needed improvements in methods of organizing and financing health services. State and local governments can also do much within their jurisdictions to express public concern and initiate public action on medical care problems. However, Federal leadership, technical aid, and financial support are needed to strengthen the Nation's medical services.

HOSPITAL INSURANCE FOR THE AGED

by

Robert M. Ball*

Commissioner of Social Security

Social insurance is a major social invention developed to help people who work for a living make provision for their own and their families' future security. Its approach to the problem of security is positive. It seeks to protect standards of living rather than merely to assist people after they have been reduced to poverty.

Social insurance adds a positive incentive for people to work, earn, save, and be self-supporting. Its benefits are available only for people who have worked and for their families, and generally the more a person earns the higher his benefits will be.

Moreover, the benefits are payable no matter how much the beneficiaries have saved on their own. Thus social insurance is a foundation that the worker can build upon. He knows that he and his family will have a source of income that will prevent them from being reduced to poverty in his old age or if he becomes disabled or dies.

These characteristics of social insurance make it the logical way to deal with a cause of economic insecurity that has assumed major importance in recent years—the high cost of the hospital care that is needed in old age.

What Is the Social Security Program?

What we know in this country as "social security" is a form of social insurance which in turn is one of two major types of insurance. Insurance distributes over a group of people and over a period of time the economic costs of the risk insured against. It works by pooling relatively small, regular contributions from a large number of people and by making payments from the pooled funds when the happening insured against occurs.

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* Mr. Robert M. Ball, a career employee of the Federal Civil Service, was appointed Commissioner of Social Security in April, 1962. Since 1939, when Mr. Ball entered the field organization of the Social Security Administration, he has worked in social security, both in and out of Government. Mr. Ball was born in New York City in 1914 and attended public school in East Orange, New Jersey. In 1935 he received his A.B. and in 1936 his M.A. in economics from Wesleyan University.

The loss insured against by social security is loss of earnings because of retirement, disability, or death. Under social security, while people are at work, they pay a small part of their earnings into social security trust funds, and these payments are matched by their employers. When earnings stop because of retirement in old age or because of disability or death, benefits are paid from the funds to partially replace the income that has been lost. The cost of paying the benefits is actuarially evaluated, and contributions sufficient to cover the cost are provided for. The benefits are spelled out in the law, and the right to the benefits is a legal right enforceable in the courts. These are the characteristics that make social insurance "insurance"; they are similar to the characteristics that make private voluntary insurance "insurance."

There are, of course, differences between social insurance and private insurance. One of the differences is in the kind of rights and obligations that are established. Under private insurance, premiums and benefits are generally fixed for the duration of a contract. Under social insurance, the right to benefits and the contributions required are spelled out in law, which can, of course, be changed by the Congress. Another difference is that social security is compulsory. Since it is assured of new entrants into the system, it does not have to maintain the kind of reserves that private insurance has to maintain. Still another difference is that, because contributions are a percentage of earnings, the income to the social security system rises as earnings rise. The additional income can be used to keep the program up to date.

Many changes have been made over the years in the social security program to improve the protection it offers. Protection for survivors and for the disabled and their dependents has been added to the program, for example, and benefits have been increased when wages and prices have risen. The fact that its benefits can be improved as conditions change is one of the very great advantages of social insurance.

Social Security Prevents Dependency

In 1934, the President set up a Committee on Economic Security to make recommendations for safeguards "against misfortunes which cannot be wholly eliminated in this man-made world of ours."[1] The Committee recommended a contributory annuity system in order to "prevent destitution and dependency . . . [which] are enormously expensive, not only in the initial cost of necessary assistance but in the disastrous psychological effect of relief upon the recipients."[2]

[1] Message of the President of the United States, June 8, 1934.

[2] Report to the President of the Committee on Economic Security, 1935, p. 33.

The key to the entire theory of social security is found in the phrase "*prevent* destitution and dependency." Social security is designed to do just this. The people who work in jobs covered by the program know in advance that when they grow old or become disabled or die their families will have some income, that they will not have to use up their savings before they can draw that income, that they can retain their dignity and financial independence.

Similarly, if hospital insurance were provided for under the social security program, working people would know in advance that much of their health costs in old age would be met through social security and that they would not have to exhaust their resources, appeal to charity, or seek public assistance when serious illness strikes.

Health Costs and Security in Old Age

When the social security program was first enacted, the primary function of the public welfare program of old-age assistance (OAA) was to take care of the needy aged who were not eligible for social security benefits. It was expected, quite correctly, that as time passed more and more of the aged would be eligible for social security and therefore would not have to seek public assistance.

With time, OAA has changed from the main program providing income for the aged to one that has the role of providing for the few who still are not eligible for social security and of providing supplementary aid for those who have special needs. Increasingly it has the latter role, and increasingly this role is required because the assets and current income of the aged have to go toward meeting health costs. Some 30 percent of the social security beneficiaries now going on the OAA rolls do so for this reason.

Most older people cannot meet the cost of the four or five spells of illness requiring hospital care that the average couple experiences after age 65. For about one-half of social security beneficiaries, their benefits are practically their sole source of support. These benefits, and other small resources the older person may have, are needed to meet regular expenses like food and rent. They cannot be used to meet large health costs.

An older person may have little or no health costs for several years and then suddenly incur costs running into thousands of dollars. Most people have some assets when they retire, and with their social security benefits they are able to get along. But for many, expensive spells of illness wipe out their resources, and they must ask for help from their children or from public assistance or go without health care they need.

Clearly it would be impossible to provide for all aged beneficiaries an increase in monthly cash benefits large enough to cover catastrophic expenses—amounting to hundreds, even thousands, of dollars in many cases. The only solution is to even out this expense through the insurance method.

The proposed hospital insurance plan would add to the cash benefit that aged people receive under social security the equivalent of about $8 a month in a paid-up hospital insurance policy. This benefit would be, in effect, an increase in the social security benefit.

It has been suggested that cash benefits be increased by an amount equal to the value of the hospital insurance and that it be left to each person to obtain his insurance privately. There are a number of reasons why this cannot be done.

First, we need to be sure that people really have the protection. If cash benefits were increased without requiring people to use the increased benefits to buy private insurance, people who need health insurance most—including people who have no other resources to meet their health needs—might use the benefit increase to meet current expenses rather than to buy health insurance. To the extent that this happened, the benefit increase would fail of its purpose.

Even if the beneficiary could be required to use the benefit increase to buy private health insurance, serious problems would remain. Some of the aged are very bad risks; they could not buy insurance at any price. Others would find the policies either too costly or inadequate. Furthermore, private insurance for the aged often has high administrative costs, because many of the policies are sold one at a time and premiums are collected from each policyholder individually. On the average, commercial health insurance sold on an individual basis pays in benefits only about 50 percent of premiums. The additional administrative cost of the proposed hospital insurance under social security, in contrast, is estimated at 3 percent of benefits.

These problems could be avoided only if private health insurance were required to meet certain standards. The Government would have a responsibility to determine, for example, that the policy was offered by a financially reliable company; that there was a reasonable relationship between premiums and benefits; that the policy was free of unreasonable exclusions and restrictions; and that the services covered by the policy were in fact health services. In addition, it would be necessary to require that the policies were made available to all the aged—to the poor risks as well as the good ones. The degree of Federal regulation

of private insurance that would be required under such a proposal would obviously be undesirable and unacceptable.

Combination of Three Methods

Some have expressed concern that the proposed hospital insurance under social security would have an adverse effect on private insurance. There is no need for such concern—for some 25 years, social security has been one member of a three-way partnership, the other two components of which are private insurance and public assistance. Social security has been the basic program in this three-way partnership. Also, it is a base to which workers are encouraged to add additional protection through private pension plans, through savings, and in other ways. The absence of a means test in social security has meant that workers have had no reason not to build up their own resources, which in public assistance would make them ineligible for aid. Today there are over 30,000 private pension plans that are intended to complement social security and help toward a good life in old age. From 1940 to 1961, life insurance in force grew from $115 billion to $685 billion.

There would be no means test in the proposed program for hospital insurance for the aged, just as there is none in the present social security program. People could supplement the social security hospital benefits just as they supplement their social security cash benefits. They could add the coverage of physicians' services, such as is provided under Blue Shield, and they could add drug coverage and other benefits that are covered under major medical expense policies. With basic hospital insurance provided under social security, many of the aged would find it within their reach to obtain full protection against the risks of health costs by supplementing social security with private insurance.

The third part of the approach to meeting the income needs of the aged is the Federal-State public assistance programs. These programs make payments to people who are in need and whose needs are not met through the other methods. Old-age assistance, of course, supplements social security benefits when these and any other income are not high enough to meet the needs.

In 1960, a new assistance program, medical assistance for the aged (MAA), was established to meet the health needs of the aged whose resources, while enough to meet day-to-day needs, are not enough to meet their medical bills. Without a hospital insurance program under social security to meet the basic health costs of the aged, however, a fully effective MAA program would be very costly.

Even if all the States could support an adequate MAA program, this approach is not acceptable as other than a backstop to social insurance. It is not good to have most of the aged living in the fear that high health costs will deprive them of their independence and, in the eyes of their neighbors, make them appear failures and objects of charity.

Hospital insurance for the aged under social security is a necessary part of the three-pronged approach to meeting the needs of our older people. Only if there is a hospital insurance program that can meet a big part of the health costs of the aged will the States be able to provide effective MAA programs for those who still need help in meeting their medical expenses.

Conclusion

President Kennedy has proposed a systematic approach to meet a need that is common to practically all the aged and that can be met only through Government action. This approach uses the going social security system. For over a quarter of a century that system has proved effective in providing income for our older people. It can be just as effective in providing protection against health costs in old age. The proposal is not one to provide health services—it is a proposal for meeting the costs of such services through insurance.

The proposed program would not cover the costs of all health services. It would not, for example, cover doctors' services. It is primarily a program to pay for hospital services for the aged, which produce the most burdensome and unpredictable health costs.

I believe this country will adopt the same approach to solving this community problem that it has followed in meeting other major social and economic problems now met through social security. I believe the Government and private enterprise will perform those activities for which each is most appropriately equipped. Hospital insurance for the aged provided through social security will be the basic program; private enterprise will play an important role in providing supplementary protection; and Government public assistance programs will fill the few remaining needs.

THE WELFARE ADMINISTRATION AND MEDICAL CARE

by

Ellen Winston*
Commissioner of Welfare

In America, as a young country with rich resources, people at first believed that almost everyone could achieve security for himself and his family through his own efforts. And, certainly, the belief was justified since there was very little chronic unemployment and money was not the necessary ingredient to life that it is today.

Efforts were made to help needy orphans, aged, sick and seriously handicapped people chiefly through private philanthropy—although even in colonial days some public institutions were maintained for their care.

As the country developed, however, with the pronounced shift from agriculture to industry and the trend toward urbanization, these informal ways of helping the poor became progressively inadequate. Compounding the problem was the virtual end of the three- and four-generation family under one roof—a development that in itself created new social and economic difficulties.

To meet this new problem of dependency in a money-oriented, interdependent society, many local governments and a few State governments established departments of public welfare to operate public institutions and to provide a minimum of assistance—usually fuel, groceries, and rent—to destitute people in their own homes.

Nevertheless, the Great Depression of the 1930's caught all levels of government equally unprepared to cope with the growing crisis of widespread poverty resulting from unemployment. The Federal Government first attempted to adhere to its traditional position that relief was a State and local responsibility. Appeals went out to private charities to share the burden. But this was

* Prior to her appointment, in January, 1963, as the first United States Commissioner of Welfare, Dr. Ellen Winston had served as Commissioner of Public Welfare of North Carolina for 18 years. A native of North Carolina, Dr. Winston received her early education in the public schools of North Carolina. She is a graduate of Converse College, and in 1930 she received the Ph.D. degree in sociology from the University of Chicago. Dr. Winston is the wife of Dr. Sanford R. Winston, author and lecturer and head of the Department of Sociology and Anthropology at North Carolina State College.

asking the impossible. Neither the States nor voluntary agencies were able to meet the impact of the greatest economic and social disaster in the history of this country. And so in 1933 the Federal Government assumed the major responsibility for the relief of unemployment. For the first time, Federal money was made available to all the States under a variety of relief and work-relief programs.

Even so, it was not until 2 years later, in 1935, with the passage of the Social Security Act, that a regular and permanent basis for using the tax powers of the Federal Government to prevent and relieve poverty was established. The Act provided for:

(1) A federally administered system of old-age insurance (later expanded to include survivors and disability insurance);

(2) A federally aided but State administered system of unemployment compensation;

(3) Federal money to States for public assistance programs for the support of needy persons 65 years of age and over (old-age assistance), for the needy blind (aid to the blind), and for dependent children whose father or mother was dead, disabled, or absent from the home (aid to dependent children). These programs are State administered, or locally administered-State supervised. Congress sets formulas which determine how much money a State must invest in the programs in relation to the Federal funds it receives.

Later two other public assistance programs were established: aid to the permanently and totally disabled, and medical assistance for the aged. In 1961 the aid to dependent children program was changed to permit States to make payments, with Federal matching funds, to families in which both parents were at home but were in need because of unemployment. The following year, the name of this program was changed to "aid to families with dependent children."

The Federal responsibility for these five public assistance programs is carried by the Bureau of Family Services in the Welfare Administration of the Department of Health, Education, and Welfare.

It is important to keep in mind that a person must be in dire financial need before he can receive help through any of the public assistance programs and that the cost of the help he receives is met through general tax revenues—Federal, State, and county. In this respect, the public assistance programs differ from social insurance, where the cost is met through payroll contributions by employee and employer, as with old-age, survivors, and disability insurance (OASDI), or by the employer alone as with unemployment insurance.

It is also important to know what is meant by a "needy" person. From the standpoint of public assistance, a person is considered needy, or dependent, if all the income he has, or can obtain from other sources, is less than the cost of the minimum standard of living as determined by his State welfare department. Public assistance is intended to make up the difference between what he has and what he needs to secure the minimum necessities of life.

But with rising costs and the shrinking value of the dollar which have characterized our postwar economy, fewer than half the States are now fully meeting the financial needs of those receiving public assistance, judged by the minimum living standards set by the States themselves. The other States either impose maximums on the monthly amount of assistance any individual family may receive or meet only a specified portion of need.

Within these limitations, every State today shares with the Federal Government the cost of providing assistance to the needy aged, blind, and dependent children. All States except Nevada have federally aided programs of aid to the permanently and totally disabled and, as of May 1963, 25 States, the District of Columbia, and 3 island territories, had programs of medical assistance for the aged.

Since the passage of the Social Security Act in 1935, major developments in the social and economic history of the United States have profoundly influenced and changed the character and extent of Federal public assistance. In fact, basic changes in the intent and approach of public assistance were enacted in 1962 and described by President Kennedy as "the most far-reaching revision of our public welfare laws since they were created in 1935."

The changes came about because of the growing recognition that poverty is a result of other social problems and that preventive and rehabilitative services are essential if we are to solve family problems, not just treat symptoms. The amendments authorize increased Federal aid to States for training personnel and for building up service programs to reduce the need for assistance among those already receiving public aid and to prevent future dependency. They represent an attempt to carry forward the American tradition of helping people to help themselves.

Actually, among all recipients of public assistance, only a small minority can be considered employable. For them, the recent public welfare amendments are expected to provide new opportunity to move from dependency to self-reliance, to get back on their own feet.

This means marshaling a variety of counseling services to help them overcome personal, social, or vocational handicaps; equipping them with skills which they can "sell" in today's labor market, and helping them to find jobs.

For many who, because of their lack of past opportunities, are unqualified for anything but unskilled labor, it means providing the education that will at least enable them to fill out job application blanks, find their way about a city, follow instructions on a machine, and learn a trade.

But the vast majority of public assistance recipients are now too old or too young for work, or blind or disabled, or needed at home to care for young children. They will continue to need financial assistance. They also need social services, especially those whose poverty or disability may have isolated them from the normal life of the community or led to family breakdown.

The Social Security Act is as humane a document as has ever been enacted. That is because its provisions are so closely linked with the lives of all Americans. Like a sensitive instrument, the Act reflects the changing currents that have come over the American scene in the last two decades.

Perhaps no single influence has made such an impact on the public assistance provisions as has the sheer growth in our population, coupled with our increased lifespan. The population of the United States has grown rapidly—currently at the rate of about 3 million a year—or the addition of a city nearly the size of Chicago each year. The increased number of children, plus a proportionate growth in the number of families broken by divorce, separation, desertion, or headed by an unmarried mother, has accounted for an upward trend since 1953 in the total number of dependent children aided through public assistance.

At the other end of the life scale is the population aged 65 years and over. By 1980 it is expected to number 25 million persons.

Today, some 2.2 million needy aged—nearly 13 percent of all those 65 years and older in the United States—are receiving old-age assistance (OAA). Significantly, however, despite the steady increase in the aged population, the number of recipients of old-age assistance has declined steadily, from 224 per 1,000 aged in June 1950 to 128 per 1,000 in June 1962.

The reason for the decline is easily explained. As the number of people reaching 65 who are eligible for social security payments has steadily increased, the need for old-age assistance is less. This in turn places less of a strain on general revenues, since the costs of financing OASDI are met through the insurance funds held in trust by the Government.

Even so, many older persons, who otherwise could get along on their social security retirement benefits, need to supplement this income through old-age assistance. Why? When the basic needs of life—food, shelter, and clothing—are assessed, there remains still another need whose importance becomes more critical each day. That is the need for medical care. And in no sector of the population is this need more acute than among the aged. The high costs of ill health in old age and the inability of many of the aged to meet these costs are only too well known to public welfare officials.

Many aged persons with health problems are forced to ask for public assistance—either to meet the emergency itself or for regular living needs after using up their resources to pay for medical care. The number of older persons who become dependent solely because of health problems is tragically impressive. Just about every third person approved for old-age assistance needs such help directly or indirectly as a result of health difficulties.

Over the years, the Social Security Act has been changed several times to enable the Federal Government to increase its share of support for medical care to persons receiving old-age assistance. The most recent expansion of medical care for OAA recipients was authorized in the Kerr-Mills Act of 1960. As a result, medical care programs for such recipients have been expanded and strengthened in most States.

At least equally important, this new legislation also, for the first time, extended medical assistance to additional aged persons of low income. The medical assistance for the aged program is intended to help persons 65 years of age or over who are not receiving old-age assistance but whose income and other resources are not sufficient to meet their medical expenses.

Under MAA, the Federal Government shares with the States in the total cost of the program, without limitation on either the individual payment or total State expenditures. The amount of Federal participation ranges from 50 percent to 80 percent of expenditures paid directly to suppliers of medical services to eligible recipients. These are called vendor payments. The higher percentages go to States with the lower per capita incomes. States may make available a broad range of medical services through MAA.

Each State determines whether it will have this program and, if so, the kinds and extent of services for which costs are to be assessed and the conditions of eligibility for such services.

If a State chooses to have an MAA program the law requires the State to provide at least two items of medical care—institutional and noninstitutional care. This requirement relates to an

overall objective of the several public assistance programs—to enable people to live in their own homes rather than in institutions. Medically, there is general acceptance of the value of care in one's own home or in home-care programs.

It is expected that at least 28 States, as well as the District of Columbia and the 3 island territories, will have MAA programs underway by July 1, 1963. Legislative proposals to establish MAA programs are under consideration in 17 other States. The Department of Health, Education, and Welfare encourages and welcomes this interest and activity. It is providing consultation to help States plan MAA programs at every opportunity. The Department hopes that before long every State will have adopted an MAA program.

It is a mistake to regard the social insurance approach as being a substitute for MAA. Nor is the social insurance plan in competition with MAA. The fact is that both programs are necessary. At best, MAA can meet a part—but a very necessary part—of the total problem of medical care for the aged by providing such care only to low-income persons who cannot afford it. In this way, MAA would provide a constructive means of supplementing the proposed social insurance plan.

Hospital insurance, as a part of the social insurance program, would actually strengthen MAA programs. A number of State directors of public assistance have indicated that they would be in a better position to establish or extend an MAA program if they knew there was a "backstop" such as hospital care available to eligible persons under the social insurance system.

Medical care under the social insurance proposal would also affect the old-age assistance program to a considerable extent. As already noted, about one-third of all OAA recipients also receive some benefits under OASDI. This one-third would be eligible for hospital insurance benefits under social security. This would eliminate the need to rely on general revenues for providing medical care to a significantly large number of needy aged in the population.

Evaulated overall, the MAA programs, if adequately financed, can fill in gaps and provide special services so that every older person can have the care he needs when he needs it.

THE CURRENT STATUS OF MEDICAL CARE IN THE UNITED STATES

by

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Surgeon General of the Public Health Service

The problem area chosen for this year's debate is: What should be the role of the Federal Government in providing medical care to the citizens of the United States? As used in this article, medical care will mean the system of arrangements through which all health services of a personal nature are produced and delivered to the population. In your study of the subject you will discover that, as with most issues involving private and public action, the alternatives are not clear cut and there is no single, simple answer to the question. Medical care has become increasingly complex and costly, and some suggested solutions to the problem have become controversial. In order to debate the issue effectively, it will be necessary to have a firm grounding in the facts regarding the structure and function of medical care in the United States today.

Unlike some other articles in this manual, which will present varying positions and points of view on the myriad issues posed, the purpose of this article is not to debate the issues but rather to present a background of facts and figures on medical care.

Let us begin by setting forth a concept of medical care which can serve as the basis for this discussion. Medical care is more than treatment of disease. It is a range of services, which must provide for the promotion of health, the prevention of disease, the diagnosis and treatment of disease and disability, and the rehabilitation and restoration of the patient to positive health. Comprehensive medical care is thus a continuum of health services provided to the individual when and where he needs them, without diminution of quality or disruption of delivery.

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This concept of medical care has four dimensions: (1) *the people served*—the individuals, families, communities that need and use personal health services; (2) *the providers of service*—the physicians, dentists, nurses, and other health personnel, as well as the hospitals, clinics, nursing homes, and other facilities in which care is provided; (3) *the financing of services*—the individual or collective mechanisms, such as insurance, through which the costs of medical care are met; and (4) *the organization of services*—the efforts both public and private to bring patients, providers, and payments together most effectively.

Each of these dimensions has changed character radically since the turn of the century. Today health services are included in the top rank of necessities that individuals and communities seek. Indeed, there is growing recognition that access to medical care has become a basic human right, an essential element along with food and shelter. The rapidly expanding field of knowledge and technology in the practice of medicine produces increasing specialization of the professions and their facilities. Comprehensive high quality medical care is expensive, and the increase in costs along with increases in demand for care has created a variety of financing mechanisms. Organization of services is complex, and the many differences in both public and private programs enhance the difficulties of assuring the best possible medical care and the most efficient use of facilities and personnel.

These then are the dimensions and the problems which will focus our discussion.

The People Served

Social and Economic Factors

The dynamics of medical care in the United States must be viewed in the context of changes in the structure of our society, the national economy, and the attitudes of people toward health and illness.

Improvements in the level of educational attainment, for example, have contributed to the emergence of a more sophisticated population that expects and is willing to seek effective medical care. With rising living standards, more families are financially able to pay for medical care. In contrast to other necessities, however, neither the anticipated need for medical care nor the expected cost of it can be predicted accurately by the family. People's attitudes are changing with respect to paying "out-of-pocket" for costly, unexpected items, and thus budgeting devices such as insurance are increasingly extended to payment for medical care.

Increased urbanization and industrialization have contributed to changing medical care patterns and problems. Households are smaller; there is seldom room to house the retired or widowed grandparent; the wife as well as the husband may be gainfully employed, creating new problems when parents or children need bedside care. Large concentrations of employees and the development of the labor union movement have stimulated group action in discovering solutions to problems of providing and financing medical care. Technological advances in industry have created new environmental and occupational hazards.

The dramatic increase in the total population of the United States has been accompanied by remarkable changes in its age composition—by increases in the number of both young people and old people. Our population, in other words, is growing both younger and older at the same time.

Changing Patterns of Mortality and Morbidity

Since the turn of the century, there has occurred a dramatic decline in mortality rates: In 1900 there were 17.2 deaths per 1,000 population, but by 1961 the death rate had been reduced to 9.3.[1] While death rates have declined in all age groups, they have been reduced most for the early years of life.

Concurrently with this reduction in mortality, marked changes in disease patterns have occurred, with emphasis shifting from communicable to chronic diseases. Early in the century the infectious diseases, such as the diarrheal diseases, pneumonia, and tuberculosis were principal hazards, and took their toll in the early years of life. Since then, medical science has developed immunization procedures which effectively prevent many of these diseases and antibiotics capable of treating others; improvements in housing, sanitation, and nutrition have greatly controlled the spread of infection and increased our capacity to resist it; and medical care has become more effective and available for prompt control of infections.

The threat to health and life from communicable diseases, however, has by no means disappeared from our population. For 1961, the National Health Survey reported that on the average, each person in the United States had two acute conditions per year, sufficient to cause restricted activity or to require medical attention. These conditions, over 70 percent of which were the

[1] Mortality statistics in this section are derived from data collected through the National Center for Health Statistics, National Vital Statistics Division, of the Public Health Service. For a more detailed discussion of mortality and morbidity than can be given here, see: Monroe Lerner, "Mortality and Morbidity in the United States as Basic Indices of Health Needs," *The Annals of the American Academy of Political and Social Science*, September 1961, Volume 337, pages 1-10.

result of communicable diseases, caused a total of 1.5 million days of restricted activity.[2]

While the mortality rate for infants under 1 year of age has declined by 75 percent since 1915, in 1959 there were still 26.4 infant deaths per 1,000 live births in the United States—a higher rate than that of 10 other nations in the world. This national rate obscures racial and geographic variations. Infant mortality in nonwhite races, for example, is 44.0 per 1,000 live births, as opposed to 23.2 for the white race. Rates for the individual States range from a low of 20.0 to a high of 39.0.

As the probability of death from these communicable diseases has decreased and more people live to advanced ages, the chronic diseases, such as heart disease and cancer, have emerged as the major health problems. Over half of all deaths are now caused by the cardiovascular diseases. Accidents rank fourth as a cause of death in all ages, but have become the leading cause of death in age groups from 1 to 34 years.

For many chronic conditions we are only at the threshold of knowledge as to their cause and treatment. For others science and medical care can combine to make possible a long and comfortable life. Diabetes, for example, can now be controlled with insulin and is no longer the fatal disease it was 40 years ago. Repeated attacks of rheumatic fever which often lead to heart disease can now be prevented with long-term penicillin therapy. Advances in the past 10 years in heart surgery are correcting congenital defects which formerly meant death in the early years of life.

The extent of chronic disease is indicated by the fact that 70 million Americans, or 41 percent of our population, have one or more chronic conditions, and 10 percent suffer some limitation of activity as a result. The problem increases with advancing years, so that 77 percent of persons 65 and older have one or more chronic conditions, and nearly half are restricted in activity.[3]

Dental diseases must also be cited among the major health problems of our time. It is estimated that Americans today have approximately 700 million untreated cavities—an average of nearly four per person. By age 65, almost everyone has developed

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[2] The United States National Health Survey is a continuing program under which the Public Health Service makes studies to determine the extent of illness and disability in the population of the United States and to gather related information. The data are reported in a series of publications. Information reported here for acute conditions is from Series B-34, June 1962. An acute condition is defined as a condition which has lasted less than 3 months and which has involved either medical attention or restricted activity. They include: infectious and parasitic diseases, colds and other respiratory conditions, and injuries such as fractures and sprains.

[3] Ibid., Series C-6, March 1961. A chronic condition is one which has lasted more than 3 months or is a condition which by its nature is considered chronic, such as asthma or hay fever, heart trouble, allergy, mental illness, visual or audio impairments, etc.

the gum diseases which in adults cause more tooth loss than is caused by decay.[4]

Mental illnesses are also very prevalent in our population. Despite trends to new types of ambulatory care of mentally ill patients, over a million people a year receive treatment in mental institutions.

Successful control of chronic physical and mental illness is dependent upon available and effective medical care, which insures early detection, accurate diagnosis, prompt medical or surgical treatment to prevent progressive disability, and rehabilitation of the patient. The advances in medical technology that make possible accurate diagnosis and effective treatment require an expanding variety of specialized health personnel.

The Providers of Service

Health Manpower

In 1960, it was estimated that there were over two million physicians, dentists, nurses, and other health personnel in the United States.[5] In 1955, the National Health Council listed 156 kinds of career opportunities in health.[6] In all probability, the number would be even greater today. The "horse and buggy" doctor of yesterday, who served as physician, surgeon, midwife, dentist, druggist, and often mortician, is gradually being superseded by the specialist physician of today, who calls upon nurses, technicians, therapists, pharmacists, and other professionals, including other specialist physicians. As medical knowledge and technology advance the capacity of our medical care system to provide effective services, it becomes increasingly apparent that no one individual can encompass the entire spectrum of knowledge or apply all the techniques.

Table 1 gives a summary picture of medical, dental, and nursing manpower in the United States for 1960.

Table 1

	Number of persons	Rates per 100,000 population
Physicians		
Doctors of Medicine (M.D.)	240,833	134
Doctors of Osteopathy (D.O.)	14,339	8
Dentists	101,508	56
Nurses (R.N.)	504,000	280

Source: "Health, Education, and Welfare Trends," Department of Health, Education, and Welfare, 1962.

[4] Commission on the Survey of Dentistry in the United States, "Dentistry in the United States, Status, Needs, and Recommendations." American Council on Education, Washington, D.C., 1960.

[5] United States Department of Health, Education, and Welfare, Public Health Service, "Chart Book on Health Status and Health Manpower," September 1961.

[6] National Health Council, "Health Careers Guidebook," New York, 1955.

The ratio of total physicians to population has remained fairly constant over the last 20 years, but there is growing concern that this supply ratio, even if it can be maintained, will be inadequate to meet our needs. Part of this concern is predicated on the rising demands of our population for medical care. But factors of distribution, technology, and patterns of practice are also significant.

If we consider only the active, non-Federal physicians, the supply ratio is reduced to around 120 per 100,000 population.[7] For both professional and economic reasons, physicians tend to concentrate in metropolitan areas, leaving rural areas with an average of fewer than 50 active physicians per 100,000.

The increasing requirements for physicians in hospital service, industry, teaching and research, and administration have contributed to this rural-to-urban shift, as well as to a decrease in the percentage of private practitioners, from 85 percent in 1931 to 66 percent in 1962.

Perhaps the most significant trend is the increasing specialization of practice. In 1931, about 16 percent of physicians were full-time specialists, but by 1962, the proportion had increased to 50 percent, dramatic evidence of the growing complexities of medical technology. The trend toward specialization also tends to exaggerate the problem of maldistribution in that specialists concentrate in urban areas where they have easy access to other specialists and to the facilities and equipment they often require, and where they are assured of enough patients needing their specialized services.

Similar problems of supply, distribution, changes in practice, and increasing demands for service are found with respect to the dental profession. It is estimated that the average dentist can take care of about 1,000 patients, but the dentist-population ratio in the United States is currently only about 1 to 1,900. Even to maintain the present dentist-population ratio, it is estimated the number of dentists graduating each year must be doubled by 1975. Poor distribution of dentists, between rural and urban areas, intensifies the shortage. To increase their productivity, dentists are beginning to use auxiliary personnel, such as dental assistants, hygienists, and laboratory technicians, in the performance of routine tasks.[8]

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[7] Information in this section on the supply, distribution, and changes in practice of physicians has been obtained from the Division of Public Health Methods, Public Health Service, and the "Health Manpower Source Book" series, PHS Publication No. 263, in particular, Section 10: Physicians' Age, Type of Practice, and Location," published in 1960; and Section 14: "Medical Specialists," published in 1962.

[8] Commission on the Survey of Dentistry, op. cit. and, Surgeon General's Consultant Group on Medical Education, "Physicians for a Growing America," Public Health Service Publication No. 709, Washington, D.C., 1959.

A recent report on needs and goals in nursing[9] suggests that there is a severe quantitative and qualitative shortage of nurses in the United States today. Although the number of active nurses has steadily increased, the demand for their services still exceeds the supply. Increasingly, practical nurses and auxiliary nursing personnel are being used to supplement or in some cases to take the place of professional nurses. In 1900, nurses worked primarily in the home, but today their services are required in hospitals, nursing homes, doctors' offices, schools, industrial settings, as well as home-care programs.

Nursing education, in recent years, has reflected these changing needs and begun to make progress toward meeting them. Hospital-administered nursing schools are moving from the former apprentice pattern of education toward well-planned curricula. Enrollment in university sponsored nursing programs leading to baccalaureate degrees has increased.

The supply of other health professionals is similarly lagging behind the demand for their services. Rehabilitation programs require more physical, occupational, and speech therapists. Hospitals and clinics require more laboratory and X-ray technologists, nutritionists, hospital administrators, medical record librarians, medical social workers, and other types of professional personnel. Home-care programs require many of these same personnel as well as public health nurses, homemakers, health educators, and other health workers.

Since specialists characteristically receive patients by referral from the family physician, the trend toward specialization places an extra responsibility on the family doctor, who is in the best position to understand the patient as a whole person rather than to treat independently his various organs or body systems. It is the family physician who interprets illness and medical care to the patient, and who coordinates the required care from several sources in the context of his family and social environment.

How long this personalized medical care can withstand the forces of the changing scene in medicine cannot be predicted. Increasingly, physicians who specialize in internal medicine or in pediatrics are replacing the general practitioner as the personal physician for adults and children respectively. Experiments with new methods and content in medical education are being conducted, and may provide an answer to the problems encountered in training the family physician of tomorrow.

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[9] "Toward Quality in Nursing, Needs, and Goals," Report of the Surgeon General's Consultant Group on Nursing, Public Health Service, February 1963.

Another approach to the problem is organized group medical practice. The potential for providing comprehensive medical care is enhanced by organizing together in one location the required team of specialists, auxiliary personnel, and technical equipment. By assigning primary responsibility for every patient to a "personal physician," this type of practice can provide a mechanism for facilitating referral of patients for consultation yet maintaining continuity of responsibility for care of the patient.[10]

Changing patterns of practice, together with increasing capacity of the population to seek and pay for medical care, have had an effect on the utilization of physician services.

In the past 30 years, the average annual number of out-of-hospital visits to physicians has nearly doubled, from 2.6 visits per person in 1928-31 to 5.0 in 1957. Not only are more persons using a doctor's service at least once a year, but those who do consult a physician, outside the hospital, average a greater number of visits. In 1928-31, for example, only 48 percent of the surveyed population had visited a physician in the past year, while the comparable figure in 1957 was 63 percent. Individuals who consulted a physician at least once a year made an average of 5.5 visits in 1928-31, and this figure increased to 7.6 in 1957.[11]

Thirty years ago, approximately 40 percent of out-of-hospital physician visits were made in the home, 50 percent in the doctor's office, and 10 percent in clinics. Today, only 10 percent of such visits are made to the home, 66 percent in the physician's office, 10 percent are telephone consultations, and the remainder take place in clinics and other locations.[12] This shift in the site for providing medical care is partly a result of increasing demands on the physician's time and the need for more diagnostic and treatment equipment than can fit into the "little black bag." Even the doctor's office today cannot provide the range of equipment and personnel for all kinds of diagnosis and treatment, and thus the physician increasingly depends upon hospitals and other community health facilities.

Health-Care Facilities

The modern hospital is the most dramatic evidence of the changing patterns of medical care. In 1873, the first census of hospitals

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[10] For further information on group practice see, for example, American Association of Medical Clinics, American Medical Association, and National Association of Clinic Managers, "Group Practice: Guidelines to Forming or Joining a Medical Group," 1962; and Esselstyn, C. B., "The Next Ten Years in Medicine," *New England Journal of Medicine*, January 18, 1962, Volume 266, pages 124-129.

[11] National Health Survey, Series B-19, August 1960, and Health Information Foundation, "The Increased Use of Medical Care," *Progress in Health Services*, October 1958, Volume 7, No. 8.

[12] Ibid.

listed 178 institutions. In 1961, the American Hospital Association listed 6,923 hospitals, with a total capacity of 1,670,000 beds and serving a daily average of 1,393,000 patients.[13] The hospital has evolved from the almshouse repository for the indigent sick to the community medical center providing the necessary equipment and services for accurate diagnosis and effective treatment of rich and poor alike.

Hospitals are generally classified by ownership (public, voluntary nonprofit, or proprietary) and by type of service (short-term general and long-term). Approximately one-third of the hospitals which have two-thirds of hospital beds are under public auspices, while two-thirds of the hospitals with one-third of the beds are under voluntary or private sponsorship. This is primarily due to the fact that State and local governments have tended to provide institutional care for patients with tuberculosis, mental illness, and other chronic diseases. The care of short-term patients (with an average stay of under 30 days) is primarily given in voluntary nonprofit general hospitals. Hospitals run for profit account for only 3 percent of all hospital beds.

The costs of hospital care are increasing at a rapid rate. Since 1946, the total expense per patient day in the short-term general hospital has risen by 273 percent, from $9.39 per day to $34.98. The expense for the average patient stay in the hospital increased from $85.57 in 1946 to $267.37 in 1961. The rise in total expenditures is partly a reflection of general price increases but is primarily a result of the increasing complexity of providing numerous technical and professional services as well as beginning efforts to raise wages of hospital employees to competitive levels—hospital payroll expenses, for example, have jumped by 521 percent since 1946, while the number of hospital employees has increased 128 percent.

Hospitals are being used at an increasing rate, obviously due in part to the increased availability of hospital beds. Admissions to short-term hospitals have increased from 97.5 per 1,000 population in 1946 to 128.4 per 1,000 in 1961. The number of patient days per 1,000 population has also increased from 888 in 1946 to 981 in 1961. The number of patient days has not increased at the same pace as admissions because new techniques in medicine have reduced the average length of stay from 9.1 to 7.6 days.

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[13] "Hospitals," Journal of the American Hospital Association, Guide Issue, August 1, 1962. This is an annual census of those hospitals which meet certain requirements for listing. The census does not include all hospitals, but it provides information on the vast majority of hospital beds in this country. Unless otherwise indicated, information in this section regarding hospitals is derived from "Hospitals," Guide Issue.

In addition to the increasing supply of hospital beds, other factors affecting hospital utilization can be identified. These include the volume of illness in the population, changing attitudes toward health and hospitalization, and progressive removal of the economic barriers to seeking hospital care. Whether or not the community has available alternative facilities for patient care, such as nursing homes and home-care programs, is also significant.

It is the physician who is responsible for admitting patients to hospitals and who generally determines how long the patient will stay. The busier doctor can see more patients and treat them more efficiently when they are located in one well-equipped facility, and thus a shortage of physicians in an area may increase hospital utilization. Both physician and patient may also be influenced in their decisions on hospitalization by the character of the patient's insurance coverage. Patients who have hospitalization insurance coverage are admitted more frequently than those without it.[14]

In addition to their patient care functions, hospitals are also the principal locus at present for the education of professional and practical nurses. They are also the site for much of the medical school, internship, and residency training of young physicians.

Hospitals are increasingly becoming organized for differentiation of functions with respect to types and intensity of patient care for various illnesses. For example, intensive care units are being designed and staffed for the special surveillance of critically ill patients who require constant supervision. The development of long-term care units, either as part of the hospital itself or as a separate facility under common control, is also making progress. As increasing concern is directed toward the problems of mental illness and the necessity for its early diagnosis and prompt treatment, more and more hospitals are becoming equipped to provide short-term, community-based care for mentally disturbed patients.

Provision of facilities for the care of ambulatory patients is also an increasingly important function of hospitals. Physicians who depend on the specialized facilities of hospitals for their ambulatory patients like to have their private offices convenient to the hospital, and some hospitals now are including space for such offices within the facility. A study of a sample of hospitals has shown that visits to hospital outpatient departments increased almost 130 percent between 1945 and 1958 and during the same period visits to hospital emergency rooms increased by 160 percent. Also of significance was the finding that 42 percent of

[14] Odoroff, M. E. and Abbe, L. M., "Use of General Hospitals: Variation with Methods of Payment," *Public Health Reports*, April 1959, Volume 74, pages 316-324.

patients seeking care in emergency rooms had "nonemergency" conditions.[15]

A major problem still exists with respect to facilities for the long-term care of the chronically ill and aged. In 1961, there were some 23,000 nursing, convalescent, or other homes for the aged, providing almost 600,000 beds, slightly over half of which are devoted to skilled nursing care as opposed to residential or personal care.[16] The vast majority of homes providing skilled nursing care are small in size—50 percent have 25 beds or less—and are operated as profit-making institutions. In 1960, the Congressional Subcommittee on Problems of the Aged and Aging described the condition of the majority of American nursing homes as follows:

> They are moderately safe, provide nursing care varying widely from indifference to warm sympathy, are generally clean and meet minimum standards of space, nutrition, and fire protection. "Routine Care" in these homes permits little recreational activity beyond a lone television set; floor space between beds and in hallways is at a premium making activity difficult and often dangerous. Routine physician attendance is rare and restorative services a vague ideal.[17]

Efforts are being made to remedy both the quantitative and qualitative adequacy of these facilities. The Hill-Burton program estimates that over half a million additional skilled nursing-home beds are currently needed. Federal support is available in the form of matching construction grants and through mortgage loan guarantees to stimulate construction of facilities that meet minimum structural and fire safety standards. Efforts are also being made to improve quality of care through such mechanisms as making the professional and technical skills of hospitals available to the nursing homes under affiliation agreements.[18]

The Financing of Services

The national economy is growing even more rapidly than the population. It is estimated that the gross national product will increase by two-thirds in the next 10 years, and this expansion with its consequent higher levels of purchasing power can be expected to make comprehensive medical care financially more acces-

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[15] Skudder, P. A., McCarroll, J. R., and Wade, P. W., "Hospital Emergency Facilities and Services: A Survey," *Bulletin of the American College of Surgeons*, March-April 1961, Volume 46, pages 44-50.

[16] United States Department of Health, Education, and Welfare, Public Health Service, "Nursing Homes and Related Facilities: Fact Book," PHS Publication No. 930-F-4, February 1963.

[17] Subcommittee on Problems of the Aged and Aging of the Committee on Labor and Public Welfare, United States Senate, "The Condition of American Nursing Homes," 1960.

[18] See, for example: Illinois Hospital Association, "A Guide for Hospital-Nursing Home Affiliation," the Association, Chicago, 1961.

sible to greater numbers of people. As a nation, we currently devote 5.7 percent of our gross national product to expenditures for health and medical care, while in 1928-29 such expenditures amounted to only 3.6 percent.[19]

An overall picture of the pattern of expenditures for health and medical services is given in Table 2.

Table 2

Public and private expenditures for health, fiscal year 1960-1961 (In millions of dollars).

Health—total expenditures		29,015
Public expenditures		6,941
Health and medical services	6,386	
General medical and hospital care civilian programs	2,315	
Defense Department and Medicare programs	778	
Veterans' hospital and medical care	932	
Public assistance	589	
Workmen's compensation and temporary disability medical benefits	459	
Medical vocational rehabilitation	20	
Maternal and child health services	152	
School health	108	
Medical research	586	
Other public health services	445	
Medical facilities construction	555	
Private expenditures		22,074
Health and medical services	21,464	
Direct Payments	14,201	
Insurance benefits	5,346	
Expenses for prepayment	912	
Industrial inplant services	275	
Philanthropy	730	
Medical facilities construction	610	

Source: "Social Security Bulletin," November 1962. (Numbers may not add to totals because of rounding.)

Approximately three-fourths of our total health expenditures derive from private sources. Private expenditures for medical care and voluntary health insurance amounted to about 6 percent of disposable personal income, and averaged $116.60 per person during 1961, an increase of over 100 percent in the per capita expenditures since 1948.[20] The percentage distribution of these private expenditures for the various component medical care services, and the changes since 1948, are given in Table 3.

[19] "Social Security Bulletin," November and December 1962. Estimates on future economic growth are from: National Planning Association "National Economic Projections, 1962-65, 1970," the Association, 1960.

[20] Ibid.

Table 3

Percent distribution of medical care expenditures, 1948 and 1961

	Percent	
	1961	1948
Hospital services	27.6	24.6
Physicians' services	27.6	31.7
Dentists' services	9.8	11.8
Medicines	19.0	19.2
Appliances	5.9	5.6
All other	10.0	7.1

Source: "Social Security Bulletin," December 1962.

The system of payment for medical care varies among the component services, reflecting divergent historical developments. Hospitals, for example, originally provided only "free" care, receiving their financial support from philanthropic endowments. Today, they are increasingly assured of full payment for each patient day from direct charges to either the patient himself, an insurance company, a voluntary prepayment plan, or a publicly supported medical care program. Drugs and appliances are considered more as economic commodities, competing in the market place for physician and patient acceptance.

The usual pattern of remuneration to physicians and dentists in the United States is that of a fee for each service performed. Traditionally, the fees are based on a "sliding scale," with patients who cannot afford the standard fee being charged less for a service than others.

Out-of-Pocket Financing

Of the private expenditures for medical care approximately 70 percent are direct or "out-of-pocket" payments by the consumer to the provider of service when, or soon after, the service is received.

A study in 1957-58 reported that 98 percent of families have some out-of-pocket expenses during the year. Half of the families in the sample spent 4.5 percent or more of their total gross family income for medical care, including 6 percent of families whose direct medical care expenses totaled 20 percent or more of their gross family income. The inequity in distribution of family expenditures is further demonstrated by the fact that families with incomes of less than $2,000 spent on the average $165 for all personal health services, amounting to 13 percent of their family income, while families with incomes of $7,500 and over averaged

$411 during the year in medical expenses, but this consumed only 3.9 percent of their family income.[21]

National Health Survey data reveal that individuals in lower income families (especially those with incomes of less than $2,000) have fewer out-of-hospital visits to physicians per year, fewer visits to physicians for prenatal care, and fewer dental visits, but use a greater number of days of hospital care than individuals in upper income families.[22]

Health Insurance

To help budget for the costs of medical care several mechanisms for prepayment have developed. In 1961, over 136 million Americans, 75 percent of the civilian population, had some form of protection against the costs of medical care.[23] Health insurance benefits received through such mechanisms paid 25.5 percent of all private expenditures for medical care. A detailed discussion of the various types, kinds, and methods of voluntary health insurance plans is not within the scope of this article, but is dealt with more fully elsewhere.[24]

Health insurance has had a major impact on the source of funds of hospitals and physicians. In 1960, 57.5 percent of hospital service costs were met by health insurance and 30.3 percent of physician services were paid by insurance.[25] Coverage of the costs of dental care, drugs, home care, and psychiatric care is only beginning, but experiments indicate that prepayment of these expenses may be feasible.

There is evidence that the public is increasingly willing to pay for comprehensive coverage of medical care expenses. In 1960, when Federal employees were offered the choice of two new health insurance plans, 90 percent of those eligible signed up. Of those who did enroll, 81 percent—almost 1.8 million employees—choose the most comprehensive range of benefits available even when this choice meant greater expense to them personally than the less comprehensive coverage.[26]

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[21] Anderson, O. W., Collette, P., and Feldman, J. J. "Family Expenditure Patterns for Personal Health Services, 1953 and 1958: Nationwide Surveys," Health Information Foundation, Research Series No. 14, New York, 1960.

[22] National Health Survey, Series B-19.

[23] Health Insurance Institute, "Source Book of Health Insurance Data: 1962," The Institute, New York, 1962.

[24] See, for example: Anderson, O. W., "Elements of Health Insurance Today," Health Information Foundation Perspectives, No. A1, 1960, or, Somers, H. M., and Somers, A. R., "Doctors, Patients, and Health Insurance," The Brookings Institution, Washington, D.C., 1961.

[25] United States Department of Health, Education, and Welfare, Public Health Service, Health Economics Series No. 1, "Medical Care Financing and Utilization," PHS Publication No. 947, 1962.

[26] Sheps, C. G., and Drosness, D. L., "Prepayment for Medical Care," *New England Journal of Medicine*, February 23, and March 2 and 9, 1961, Volume 264, Pages 390-396, 444-448, and 494-499.

Twenty-five percent of the population has no insurance coverage. A 1960 study reported that the major gaps in enrollment under health insurance occurred among the aged, the nonwhite population, rural farm residents, low income families, unemployed persons, and unmarried individuals.[27]

Government Financing

The proportion of expenditures for health and medical care met by Federal, State, and local government has remained fairly constant during the past decade at approximately 25 percent of the total. Public funds for health are allocated to a variety of purposes either directly or indirectly related to the provision of medical care. Federal Government support of medical research, for example, now amounts to over half of all funds spent in seeking basic knowledge in the cause and cure of disease. The Hill-Burton Hospital Survey and Construction Act has made a major contribution toward increasing the supply of hospital and other medical care facilities, by helping to finance the construction of almost 200,000 beds now in use, and 1,300 health units.[28]

Other, more direct, activities on the part of government include: general public health services directed at communitywide problems; maternal and child health programs; the provision of direct medical care to special population groups such as veterans, members of the armed forces and their dependents, Indians and Alaska natives, merchant seamen, and individuals with tuberculosis, mental illness, and leprosy; the purchase of medical care for such groups as recipients of public assistance, crippled children, and disabled adults under the Vocational Rehabilitation program and through workmen's compensation and temporary disability programs.

The Organization of Services

The discussion to this point has revealed that medical care is provided to people by many different kinds of health personnel working in a variety of facilities and being paid through a myriad of financing mechanisms. In order to bring the patients, providers, and payments together at the right time and in the most efficient way some attention must be paid to the organization of services.

Public and private efforts toward development of an effective organization of the medical care system focus on the need to

[27] Health Information Foundation, "The People Without Health Insurance," *Progress in Health Services*, Volume 10, No. 8, October 1961.

[28] United States Department of Health, Education, and Welfare, Public Health Service, "Hill-Burton Program Progress Report, July 1, 1947-June 30, 1962," PHS Publication No. 930-F-3, 1962 Edition.

coordinate the range of comprehensive services necessary to serve the population, avoiding duplication of services while filling in the gaps that may exist, and on the need to insure that existing services are utilized most efficiently while providing the highest quality of care possible. This is the goal of an emerging concept of community medicine, which would involve ". . . the organizational and functional relationships of the professional and technical groups, the facilities, and the financial resources through which comprehensive health care may become a reality in every community."[29]

A major provision of the Community Health Services and Facilities Act, enacted by the Congress in 1961, provides a mechanism which aims toward achievement of at least part of this goal. Under this program, Federal grants may be made to State and local community agencies for development of new or improved methods of providing out-of-hospital services particularly to the chronically ill and aging. The projects which have been initiated under this program include a variety of approaches to the organization of health services. For example: the development of a central information and referral service designed to aid physicians, patients, and community agencies in locating and using the services most appropriate to their needs; the organization of home-care programs which will provide coordinated services and facilitate earlier discharge from hospitals; the development of mechanisms by local medical societies to evaluate the services rendered by physicians in private practice; the inauguration by a rural medical group practice clinic of a program to mobilize and develop resources for comprehensive care.

To coordinate the provision of medical care on a wider geographical basis, interest in regional planning is developing and receiving Federal financial support. Regional hospital planning councils are coming into existence and working with State Hill-Burton authorities to plan the location of new hospitals and to develop relationships among hospitals so that smaller, less well-equipped facilities will have access to the professional and technical services of larger hospitals. Such planning reduces the costly duplication of expensive equipment and makes more efficient use of specialized personnel while at the same time keeping hospital facilities easily accessible to more people.

Concern with the rising costs of hospital care has stimulated some Blue Cross plans to impose requirements on their member hospitals to review utilization practices. Thus, some hospitals are

[29] Stewart, William H., "Community Medicine, An American Concept of Comprehensive Care," *Public Health Reports*, February 1963, Volume 78, pages 93-100.

forming "utilization review committees" composed of physicians who regularly review the hospital records of patients staying longer than a certain period to determine if the longer stay is justified medically and socially.

Increased attention is also being directed to the development and implementation of standards for the quality of care provided. The Joint Commission on Accreditation of Hospitals, for example, assumes responsibility for accrediting those hospitals which meet certain standards of quality. In 1961, approximately 70 percent of the voluntary short-term hospitals listed by the American Hospital Association had achieved standards for accreditation. Some hospitals make use of medical and professional audits which review the standards of medical practice and provide data to evaluate the performance of its professional staff. The certification of specialists by American Specialty Boards and the continuing education requirements of the American Academy of General Practice are other examples of voluntarily administered controls which foster high standards of medical care. Governmental programs aimed at maintaining the quality of care include the licensure by States of professional personnel and medical facilities, the Federal regulation of drugs and biologicals, and the application of quality standards in certain publicly supported medical care programs.

In spite of the progress which has been made in standard-setting, serious deficiencies still exist. Maintenance of satisfactory licensure standards for certain nonhospital facilities presents serious difficulties. Licensing of the new types of health personnel, such as technicians and therapists, lags far behind their employment. As new services emerge on the medical care scene, new methods of assuring the quality of the care they provide will need to be developed and maintained.

Summary

The current status of medical care in the United States is characterized by increasing demands on and utilization of its resources, increasing capacity to provide effective medical care, increasing costs and expenditures, and increasing complexity requiring new methods of organizing and coordinating multiple services. A medical care system exists only to serve people, and if it can provide comprehensive services of high quality without fragmentation of care or disruption of service, then it will serve them well. This is the goal of medical care. The challenge has been stated by

President Kennedy in his health message to Congress on February 7, 1963:

> Good health for all our people is a continuing goal. In a democratic society where every human life is precious, we can aspire to no less. Healthy people build a stronger nation, and make a maximum contribution to its growth and development.
>
> This national need calls for a national effort—an effort which involves individuals and families, States and communities, professional and voluntary groups, in every part of the country. The role of the Federal Government, although a substantial one, is essentially supportive and stimulatory. The task is one which all of us share to improve our own health, and that of generations to come.

GOVERNMENT PUBLICATIONS RELATING TO MEDICAL CARE

The publications listed below are for sale by the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402. The title and catalog number should be given, and check, money order, or Government Printing Office coupon sent with the order.

Acute Conditions, Geographic Distribution, United States, July 1960—June 1961. Catalog No. FS 2.85: B–34. 30¢

Acute Conditions, Seasonal Variations, United States, July 1957–June 1961. Catalog No. FS 2.85:B–33. 40¢

Areawide Planning of Facilities for Long-Term Treatment and Care. Catalog No. FS 2.74/3:B–1. 55¢

Background Facts on the Financing of the Health Care of the Aged. Catalog No. Y 4.Ag 4:H 34/4. 20¢

Basic Facts on the Health and Economic Status of Older Americans. Catalog No. Y 4.Ag 4:H 34/2. 15¢

Casework Services in Public Assistance Medical Care. Catalog No. FS 3.2:M 46/5. 50¢

Children and Youth, Selected Health Characteristics, United States, July 1957–June 1958. Catalog No. FS 2.85:C–1. 35¢

Chronic Conditions Causing Limitation of Activities, United States, July 1959–June 1961. Catalog No. FS 2.85:B–36. 35¢

The Costly Time Lag Between Discovery and Use of Medical Knowledge. Catalog No. FS 2.2:T 48. 20¢

Currently Employed Persons, Illness and Work-Loss Days, United States, July 1959–June 1960. Catalog No. FS 2.85:C–7. 35¢

Developments in Aging, 1959–1963. Catalog No. 88–1:S.rp8. 60¢

Disability Days, United States, July 1959–June 1960. Catalog No. FS 2.85:B–29. 40¢

Duration of Limitation of Activity Due to Chronic Conditions, United States, July 1959–June 1960. Catalog No. FS 2.85:B–31. 30¢

Federal Expenditures for Medical and Health-Related Research, 1960–1963. Catalog No. FS 2.22/33:1. 20¢

Filial Responsibility in the Modern American Family. Catalog No. FS 3.2:F 21/3. 25¢

Financing Old-Age, Survivors, and Disability Insurance. Catalog No. FS 3.41:959. 25¢

Foundation Expenditures for Medical and Health-Related Research and Education, 1960. Catalog No. FS 2.22/33:2. 20¢

Geographic Divisions and Large Metropolitan Areas, Selected Health Characteristics by Area, United States, July 1957–June 1959. Catalog No. FS 2.85:C–6. 35¢

Geographic Regions and Urban–Rural Residence, Selected Health Characteristics by Area, United States, July 1957–June 1959. Catalog No. FS 2.85:C–5. 35¢

Health and Economic Conditions of the American Aged (A Chart Book). Catalog No. Y 4.Ag 4:H 34/3. 15¢

The Health-Care of the Aged: Background Facts Relating to the Financing Problem. Catalog No. FS 3.2: Ag 3/3. 50¢

Health, Education, and Welfare Trends, 1962 Edition. Catalog No. FS 1.19:962. $1.00

Health Services for Mentally Retarded Children, A Progress Report, 1956–1960. Catalog No. FS 3.202:M 52/2/956–960. 30¢

Health Services for the Aged Under the Social Security Insurance System, Hearings on H.R.–4222. (4 volumes): Volume 1, $2.00; Volume 2, $2.00; Volume 3, $1.75; Volume 4, $1.50.

Hill-Burton Program, Progress Report, July 1, 1947–June 30, 1962. Catalog No. FS 2.95:947–62. 45¢

Hill-Burton State Plan Data, A National Summary as of January 1, 1962. Catalog No. FS 2.74/3:F–2. 50¢

Hope, The Anchor of Life. Catalog No. FS 1.2:H 77. 40¢

Hospital Discharges and Length of Stay: Short-Stay Hospitals, United States, 1958–1960. Catalog No. FS 2.85:B–32. 40¢

Hospital Utilization Studies, Selected References Annotated. Catalog No. FS 2.74/3:G–4. 25¢

How the Government Works for Older People. Catalog No. Y 3.F 31/15:2 G 74. 40¢

Manpower for Medical Research Requirements and Resources, 1965–1970. Catalog No. FS 2.22/33:3. 55¢

Medical Care Financing and Utilization. Catalog No. FS 2.99:1. $1.50

Medical Care in the United States, The Role of the Public Health Service. Catalog No. FS 2.2:M 46/7. 35¢

Medical Resources Available to Meet the Needs of Public Assistance Recipients. Catalog No. Y 4.W 36:M 46/2. 30¢

Medical School Facilities, Planning Considerations. Catalog No. FS 2.6/2:M 46/3. 45¢

Medical Specialists. Catalog No. FS 2.2:M 31/sec.14. $1.25

Mental Retardation: Activities of the U.S. Department of Health, Education, and Welfare, 1962. Catalog No. FS 1.2:M 52/2. 50¢

Message From the President of the United States Relative to the Elderly Citizens of Our Nation. Catalog No. 88–1: H.doc.72. 10¢

The Nation and Its Older People. Catalog No. FS 1.2: 01 1/3. $1.25

The National Institutes of Health. Catalog No. FS 2.22: N 21/2/963. 35¢

New Population Facts on Older Americans, 1960. Catalog No. Y 4.Ag 4: P 81. 20¢

Nursing Homes, An Annotated Reading List. Catalog No. FS 2.24: N 93/2. 15¢

Nursing Homes and Related Facilities, Fact Book. Catalog No. FS 2.74/3: F–4. 70¢

Persons Injured by Detailed Type and Class of Accident, United States, July 1959–June 1961. Catalog No. FS 2.85: B–37. 40¢

Physicians' Age, Type of Practice and Location. Catalog No. FS 2.2: M 31/sec.10. 55¢

The Placement Process in Vocational Rehabilitation Counseling. Catalog No. FS 13.207: 545. 35¢

Principles for Planning the Future Hospital System. Catalog No. FS 2.2: H 79/23. $1.25

Psychological Aspects of Physical Disability. Catalog No. FS 13.207: 210. 60¢

The Report of the U.S. Public Health Mission to the Union of Soviet Socialist Republics. Catalog No. FS 2.2: Un 3. 45¢

Selected Impairments by Etiology and Activity Limitation, United States, July 1959–June 1961. Catalog No. FS 2.85: B–35. 40¢

Total Rehabilitation of Epileptics, Gateway to Employment. Catalog No. FS 13.202: Ep 4. $1.25

Toward Quality in Nursing, Needs and Goals—Report of the Surgeon General's Consultant Group on Nursing. Catalog No. FS 2.2: N 93/47. 50¢

U.S. Department of Health, Education, and Welfare Programs for Senior Citizens in 1962. Catalog No. FS 1.2: Se 5. 15¢

Veterans, Health and Medical Care, United States, July 1957–June 1958. Catalog No. FS 2.85: C–2. 40¢

Vocational Rehabilitation of the Mentally Retarded. Catalog No. FS 13.207: 123. 65¢

Volume of Physician Visits, United States, July 1957–June 1959. Catalog No. FS 2.85: B–19. 40¢

Your Social Security: Old Age, Survivors and Disability Insurance Benefits Under the Social Security Law. Catalog No. FS 3.35: 35/21. 10¢